

AUG 7 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

26454
Do not use this space.

1. PLACE OF DEATH
 (a) County Putnam Registration District No. 114
 (b) Township Jordan Primary Registration District No. 5869
 (c) City Portageville (d) Street No. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
 470
 2. PRINT FULL NAME Mattie Silbs
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 74. COLOR OR RACE Black 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
 6A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF Robert Silbs
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 3-20-1897
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
42 3 25
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Miss
 FATHER 13. NAME Pat Reed
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Miss
 MOTHER 15. MAIDEN NAME Martha Doherty
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Miss
 17. INFORMANT (ADDRESS) Mag-naha Silbs
 18. BURIAL, CREMATION, OR REMOVAL PLACE Putnam Co. Mo. 7/16-39
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) R. M. Payne Portageville, Mo.
 20. FILED _____ 19 _____ Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July, 15th, 39
 22. I HEREBY CERTIFY, That I attended deceased from July, 8th, 39 only 19____ to _____, 19____
 I last saw her alive on July, 8, 39, 19____. Death is said to have occurred on the date stated above, at 3 P. m.
 The principal cause of death and related causes of importance were as follows:
Acute Dysentery June 25, 39
 Date of onset
 Other contributory causes of importance:
None
 Name of operation No Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? No
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____
 Manner of injury _____
 Nature of injury _____
 24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) Pat Reed M. D.
 (Address) Portageville, Mo.
 5

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

RECEIVED
M. J. Duhaney, M. D.
District Health Officer No. 31
Special Agent
District File Number 87-92954
Date Filed 8/4/39

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

26454
Do not use this space.

1. PLACE OF DEATH

(a) County Pemissat Registration District No. 114
(b) Township Godair Primary Registration District No. 3869
(c) City _____ (d) Street No. _____ Registered No. 20
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Mattie Sills

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE Black 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) man.
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Robert Sills
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 3-20-1897
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
42 3 25
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

FATHER 13. NAME Pat Reed

FATHER 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

MOTHER 15. MAIDEN NAME Martha Boby

MOTHER 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

17. INFORMANT (ADDRESS) Mag Sills

18. BURIAL, CREMATION, OR REMOVAL PLACE Point Pleasant DATE 7/16 1939

19. FUNERAL DIRECTOR (ADDRESS) R. M. Payne
Portageville Mo

20. FILED 7-31 1939 Mary W. Cook Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-13-1939

22. I HEREBY CERTIFY, That I attended deceased from 7-8 1939 to _____, 19____
I last saw him alive on 7-8, 1939. Death is said to have occurred on the date stated above, at 3 P. m.
The principal cause of death and related causes of importance were as follows:

acute Dysentery Date of onset 6/24/39

Other contributory causes of importance: none

Name of operation no Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____ Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) A. A. Reeder M. D.

(Address) Portageville Mo

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

S-26454

1939